Filing at a Glance

Company:	Symetra Life Insurance Company
Product Name:	MIB Application Revision
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	08/21/2012
SERFF Tr Num:	SYMT-128597574
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	LUC-18 1/13
Implementation Date Requested:	On Approval
Author(s):	Lisa Hampton
Reviewer(s):	Linda Bird (primary)
Disposition Date:	08/27/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Symetra Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *MIB Application Revision*
Project Name/Number: *MIB Application Revision/LUC-18 1-13 et al*

General Information

Project Name: MIB Application Revision
Project Number: LUC-18 1-13 et al
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Lisa Hampton

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/27/2012
State Status Changed: 08/27/2012
Created By: Lisa Hampton
Corresponding Filing Tracking Number:

Filing Description:

Symetra Life Insurance Company
NAIC# 1129-68608
FEIN# 91-0742147

RE: LUC-18 1/13 – Insured Childrens Benefit Application
LUC-128 1/13 – Simplified Issue Application
LUC-141 1/13 – Variable Life Insurance Application
LUC-168 1/13 – Life Insurance Application – Part 1
LUC-170 1/13 – Life Insurance Application – Part 1
LO-1147 1/13 – Application for Reinstatement and Evidence of Insurability

We are submitting copies of final versions of the above referenced forms for your review and approval. The content does not deviate from normal company or industry standards. These forms replace the following forms:

LUC-18 10/07 – approved 2/7/08 under SERFF filing SYMX-125435809
LUC-128 10/07 - approved 2/7/08 under SERFF filing SYMX-125435809
LUC-141 6/06 – approved 12/12/06 under SERFF filing USPH-6UAS3Y161/00
LUC-168 8/11 – approved 9/2/11 under SERFF filing SYMT-127387265
LUC-170 10/11 – approved 12/8/11 under SERFF filing SYMT-12734895
LO-1147 5/07 – approved 10/29/07 under SERFF filing SYMX-125317732

We have revised the authorization to comply with the recent change to the MIB General Rules, effective 1/1/2013. There are no other changes to these forms.

If you have questions, please contact me at the numbers noted below.

Sincerely,
Elizabeth A. Hampton

State: *Arkansas* ***Filing Company:*** *Symetra Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *MIB Application Revision*
Project Name/Number: *MIB Application Revision/LUC-18 1-13 et al*

Contract Analyst
lisa.hampton@symetra.com
425-256-5468
800-796-3872 ext 65468

Company and Contact

Filing Contact Information

Lisa Hampton, Senior Compliance Analyst lisa.hampton@symetra.com
777 108th Ave. NE, Suite 1200 425-256-5468 [Phone]
Bellevue, WA 98004-5135 425-256-5466 [FAX]

Filing Company Information

Symetra Life Insurance Company | CoCode: 68608 | State of Domicile: Washington
777 108th Ave NE, Suite 1200 | Group Code: 1129 | Company Type: Insurance
Bellevue, WA 98004-5135 | Group Name: | State ID Number:
(800) 796-3872 ext. [Phone] | FEIN Number: 91-0742147

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	No
Fee Explanation:	6 forms @ 50.00 each
Per Company:	No

Company	Amount	Date Processed	Transaction #
Symetra Life Insurance Company	$300.00	08/21/2012	61877778

SERFF Tracking #:	*SYMT-128597574*	***State Tracking #:***		***Company Tracking #:***	*LUC-18 1/13*

State:	*Arkansas*	***Filing Company:***	*Symetra Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB Application Revision*		
Project Name/Number:	*MIB Application Revision/LUC-18 1-13 et al*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/27/2012	08/27/2012

SERFF Tracking #:	*SYMT-128597574*	***State Tracking #:***		***Company Tracking #:***	*LUC-18 1/13*

State:	*Arkansas*	***Filing Company:***	*Symetra Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB Application Revision*		
Project Name/Number:	*MIB Application Revision/LUC-18 1-13 et al*		

Disposition

Disposition Date: 08/27/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	ICB Application		Yes
Form	Simplified Issue Application		Yes
Form	Variable Life Application		Yes
Form	Reinstatement Application		Yes
Form	Simplified Issue SPL Application		Yes
Form	Part I Life Application		Yes

SERFF Tracking #:	*SYMT-128597574*	***State Tracking #:***		***Company Tracking #:***	*LUC-18 1/13*

State:	*Arkansas*	***Filing Company:***	*Symetra Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB Application Revision*		
Project Name/Number:	*MIB Application Revision/LUC-18 1-13 et al*		

Form Schedule

Lead Form Number: LUC-18 1/13

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		LUC-18 1/13	AEF	ICB Application	Initial:	50.900	LUC-18 1-13.pdf
2		LUC-128 1/13	AEF	Simplified Issue Application	Initial:	50.200	LUC-128 1-13.pdf
3		LUC-141 1/13	AEF	Variable Life Application	Initial:		LUC-141 1-13.pdf
4		LO-1147 1/13	AEF	Reinstatement Application	Initial:	50.200	LO-1147 1-13.pdf
5		LUC-168 1/13	AEF	Simplified Issue SPL Application	Initial:	50.100	LUC-168 1-13.pdf
6		LUC-170 1/13	AEF	Part I Life Application	Initial:	52.100	LUC-170 1-13.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

INSURED CHILDREN'S BENEFIT APPLICATION
PART III LUC-18 1/13

SYMETRA LIFE INSURANCE COMPANY
777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135

Mailing Address:
PO Box 84068
Seattle, WA 98124-9918

This application is for Insured Children's Benefit to be included in the policy applied for on the proposed insured.

1. Print name of proposed insured (as shown in Life App Part I)

_____

2. Date of application of proposed insured

Month _____ Day _____ Year _____

3. Insured Children's Benefit applied for:

No. of units _____

Maximum Units 10

1 unit = $1,000

4. Benefit	Relationship	Sex	Name	State of Birth	Date of Birth			Age Last Birthday	Height		Weight
					Mo.	Day	Yr.		Ft.	In.	Lbs.
I.C.B.	Child										
(Maximum	Child										
Issue	Child										
Age 17)	Child										
	Child*										

*If more room is needed, use an additional Insured Children's Benefit Application.

5. Has any application or policy for life or health insurance ever been declined, special rated, restricted, postponed, canceled or reinstatement denied? . . . . . **Yes** ☐ **No** ☐

6. In the past 10 years, to the best of your knowledge, has any person to be insured under the Insured Children's Benefit:

a. Had any illness, disease, injury, physical or mental impairment? . . . . . ☐ ☐

b. Had any surgical operation, been hospitalized, or had any examination or treatment by a physician? . . . . . ☐ ☐

c. Been advised to have surgery or to be treated for any condition? . . . . . ☐ ☐

d. Been medically diagnosed as having or received treatment from a member of the medical profession for Human Immunodeficiency Virus (HIV) antibodies in blood; Acquired Immune Deficiency Syndrome (AIDS); or AIDS Related Complex (ARC)? . . . . . ☐ ☐

7. For those under age one, was birth premature or abnormal in any way? . . . . . ☐ ☐

If any question above is answered "yes" give details in section 8.

8. Details of answers to Questions 5 – 7

Ques. No.	Person	Details	Name and complete address of attending physicians or hospitals	Onset Date	Recovery Date

I/(we) represent that the statements and answers recorded on this application are true and complete to the best of my/(our) knowledge and belief and agree that they shall form a part of any insurance policy issued hereon.

A copy of this application has been furnished to me/(us). I have read and understand the Notice of Insurance Information Practices on the reverse side.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiner, government unit, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Company. This disclosure Authorization will permit employees, agents or reinsurers of Symetra Life Insurance Company to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug or alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Company obtains medical information only in connection with specific products or claims. Symetra Life Insurance Company will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This Authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this Authorization or twenty-four (24) months after the date of signing this Authorization. The individual signing this Authorization has the right to revoke Authorization in writing, except to the extent that action has been taken in reliance on the Authorization, or during a contestability period. A written statement revoking this Authorization delivered to Symetra Life Insurance Company at its usual business address will revoke this Authorization. Any copy of this Authorization shall have the same authority as the original. I also understand that I or my representative have a right to receive a copy of this Authorization upon request.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signed this _____ day of _____ , _____ at _____ State of _____
Day Month Year

I certify that I have truly and accurately recorded on the application the information supplied by the proposed insured.

X_____
Signature of Agent

X_____
Signature of Proposed Insured (Age 15 or older)

X_____
Applicant's Signature

X_____
Parent or Guardian if other than Applicant

*Symetra Life Insurance Companies include: Symetra Life Insurance Company, Symetra National Life Insurance Company.

NOTICE OF INSURANCE INFORMATION PRACTICES

MIB, Inc. (Medical Information Bureau, MIB) – Information regarding your insurability will be treated as confidential. Symetra Life or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Information for consumers about MIB may be obtained on its website at www.mib.com. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB may also be contacted at 1-866-692-6901 (TTY 1-866-346-3642).

Symetra Life or its reinsurers may also release information in its file to others insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Investigative Consumer Report – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, smoking habits, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this with the application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You, or your authorized representative, are entitled to a copy of this Notice.

Disclosure to Others – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to the Medical Information Bureau.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the appropriate Individual Underwriting & Issue Department of Symetra Life, PO Box 84068, Seattle, WA 98124-9918. Your comments will be carefully considered and corrections made where justified.

LIFE INSURANCE — SIMPLIFIED APPLICATION
PART I LUC-128 1/13

Mail completed application to:
Symetra Life Insurance Company
Attn: Bank Unit
PO Box 84068
Seattle, WA 98124-9918

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135

PROPOSED INSURED INFORMATION

Insured Name First Middle Last	☐ Male ☐ Female	Soc. Sec. No.
Address Street/PO Box City State Zip		
Daytime Phone Evening Phone		

Occupation	Annual Income	State or Foreign Country of Birth

Height	Weight	Driver's License #	Date of Birth

Owner if other than Proposed Insured Soc. Sec./Tax ID:

Owner Address Street/PO Box City State Zip

Insurance Needed For:
☐ Debt Obligations ☐ Family Income Needs ☐ Business Needs ☐ Other _____

BENEFICIARY NAME	Relationship	Primary	Contingent	%
		☐	☐	
		☐	☐	
		☐	☐	
Any living children born of this marriage or legally adopted to share equally.		☐	☐	

COVERAGES

Plan Choice

☐ 10-Year Term ☐ 20-Year Term ☐ Other _____

☐ Universal Life Plan (UL) _____ Death Benefit Option (please select one option) ☐ Level ☐ Increasing

Amount of Life Insurance Coverage $_____

Supplemental Benefits ☐ Insured Children's Benefit: No. of units _____ Maximum units 5 (1 unit = $1,000)

☐ Waiver Benefit (UL Only) ☐ Other _____

PERSONAL HISTORY

	Yes	No
1. In the past 12 months, have you used any form of tobacco or nicotine based products?	☐	☐
2. In the past 12 months, has the Proposed Insured been admitted or advised to be admitted to a hospital except for normal childbirth?	☐	☐
3. Is the Proposed Insured currently disabled or unable to perform all the regular duties of his/her occupation?	☐	☐
4. In the past 10 years, has the Proposed Insured had a motor vehicle violation of driving under the influence of alcohol or drugs, had their license suspended, or been convicted of reckless driving, participated in aviation activities as a pilot or crew member, or engaged in parachuting, mountain and/or rock or ice climbing, hang-gliding, or racing of any motor driven vehicle or craft?	☐	☐
5. In the past 10 years, has the Proposed Insured tested positive for or been treated for the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS) caused by HIV infection or other sickness or condition derived from such infection?	☐	☐

6. In the past 10 years, has the Proposed Insured been hospitalized or received medical advice for:

	Yes	No		Yes	No
Heart disease or disorder	☐	☐	Major depression, bipolar disorder, schizophrenia, or suicide attempt	☐	☐
Cancer (not including basal cell)	☐	☐	Stroke or transient ischemic attack	☐	☐
Leukemia	☐	☐	Lymphoma	☐	☐
Kidney disease or disorder (not kidney stones)	☐	☐	Diabetes	☐	☐
Pancreas disease or disorder	☐	☐	Liver disease (not hepatitis A)	☐	☐
Crohn's disease or ulcerative colitis	☐	☐	Respiratory disease or disorder (not asthma)	☐	☐
Central nervous system disease or disorder (such as MS, epilepsy, paralysis)	☐	☐	Alcohol or drug dependency	☐	☐

REMARKS

Please explain any yes answer to questions 2-6 under Personal History, including doctor names, addresses and dates and treatments. Special Note: If someone other than the Proposed Insured will own this policy, provide name, social security number or Tax I.D. here.

REPLACEMENT

7. Do you have any other existing life insurance policies or annuity contracts with this or any other company? (in force or applied for) — Yes ☐ No ☐

Company	Face Amount	Policy Type	Annual Premium

8. To the best of the applicant's knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (if yes, attach state replacement disclosure) — Yes ☐ No ☐

9. If the policy being replaced has cash value or surrender charges, please provide this information in the remarks section.

AGENT

10. Does the applicant have any existing life insurance policies or annuity contracts with this or any other company? — Yes ☐ No ☐

11. To the best of your knowledge, will this insurance replace or change any existing life insurance or annuity? — ☐ ☐

12. If replacing, how does this policy better serve the applicant's needs?

PAYMENT AND TEMPORARY INSURANCE

Premium Payment Frequency:

☐ Monthly Automatic Bank Draft (EFT)* ☐ Other _____ Payment with Application $_____

For future payments taken by EFT, please complete the following information. *Marking this box authorizes us to automatically deduct from your checking or savings account by electronic funds transfer (EFT).

Name on Account	☐ Checking ☐ Savings	Bank Name
Routing Number	Account Number	Draft Date (date cannot be the 29th, 30th or 31st)

If your face amount is $250,000 or less and you answered "no" to questions 2-6, you will be covered under the temporary insurance agreement if a check is collected for the initial payment or if you sign up for initial payment by EFT.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiner, government unit, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Companies.* This disclosure authorization will permit employees, agents or reinsurers of Symetra Life Insurance Companies to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug, alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of the Human Immunodeficiency Virus (HIV) and/or other sexually-transmitted diseases. Symetra Life Insurance Companies obtain medical information only in connection with specific products or claims. Symetra Life Insurance Companies will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this authorization or twenty-four (24) months after the date of signing this authorization. The individual signing this authorization has the right to revoke an authorization in writing, except to the extent that action has been taken in reliance on the authorization, or during a contestability period. A written statement revoking this authorization delivered to Symetra Life Insurance Companies at their usual business addresses will revoke this authorization. Any copy of this authorization shall have the same authority as the original. I also understand that my representative, or I have a right to receive a copy of this authorization upon request.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I, the Owner, certify under the penalties of perjury that (1) the number shown in Applicant Info section is my correct taxpayer identification number, and (2) I am not subject to backup withholding.

I (we) agree that all the statements and answers recorded on this application are true and complete to the best of my/our belief and knowledge and shall form a part of any policy issued. I have also read the Temporary Life Insurance Agreement. (Maximum Coverage is $250,000)

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

I acknowledge this insurance policy was not a prerequisite to receiving credit, property or services from the bank and that the amount of insurance I am applying for may not meet my complete financial needs. I have received information both orally and in writing stating that this insurance product is not a deposit or other obligation of, or guaranteed by, the bank or an affiliate of the bank and that the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of the bank.

Signed this _____, at _____, State of _____
Date City State

_____ _____
Printed Name of Proposed Insured Print Name of Writing or Authorized Agent

_____ _____
Signature of Proposed Insured (Age 15 or older) Signature of Writing or Authorized Agent

_____ _____ _____
Signature of Applicant/Owner ** if other than Proposed Insured Agent Phone Agent Stat Number

_____
Agent Email

Branch Name _____ Branch # _____ 7-Digit Cost Center # _____ Rep ID # _____

* Symetra Life Insurance Companies include: Symetra Life Insurance Company, Symetra National Life Insurance Company.
** If applicant is corporation/partnership, a corporate officer/partner other than proposed insured must sign.

NOTICE OF INSURANCE INFORMATION PRACTICES

MIB, Inc. (Medical Information Bureau, MIB) – Information regarding your insurability will be treated as confidential. Symetra or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Symetra Life or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Investigative Consumer Report – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, smoking habits, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this in the remarks section on the reverse side of this application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You, or your authorized representative, are entitled to a copy of this Notice.

Disclosure to Others – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to the Medical Information Bureau.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Individual Underwriting & Issue Department of Symetra Life, PO Box 84068, Seattle, Washington 98124-9918. Your comments will be carefully considered and corrections made where justified.

TEMPORARY LIFE INSURANCE AGREEMENT

AMOUNT OF COVERAGE: If the Temporary Life Insurance questions (questions 2-6 in personal history section) have been answered "no" and if money has been accepted as advance payment for life insurance and the proposed insured dies while this temporary insurance is in effect, we will pay the beneficiary an amount equal to the lesser of:

(a) the amount of all death benefits applied for with this application, including any accidental death benefits, if applicable; or
(b) a maximum amount under all Temporary Life Insurance Agreements with Symetra Life of $250,000.

COVERAGE BEGINS: Life insurance under this Agreement will begin on the date of this application, if the Temporary Life Insurance questions have been completed and answered "no" and money equal to the first full premium has been accepted as advance payment for life insurance.

COVERAGE ENDS: Life insurance under this Agreement will terminate on the earliest of:

(a) 90 days from the date of this Agreement; or
(b) the date that insurance takes effect under the policy applied for; or
(c) the date a policy, other than as applied for, is offered to the applicant; or
(d) the date the Company mails notice of termination of coverage and a return of the payment to the applicant.

LIMITATIONS:

(a) This Agreement does not provide benefits for disability.
(b) Fraud or material misrepresentation in the application or in the answers to the questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of the payment made.
(c) If the proposed insured is less than 15 days old or more than 80 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
(d) If the proposed insured commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made. (For citizens of Missouri, suicide is no defense unless we can show that the insured intended suicide when the application was completed.)
(e) If the check or draft submitted as payment is not honored by the bank, there is no coverage under this Agreement.
(f) No one is authorized to waive or modify the terms of this Agreement.

LIFE INSURANCE APPLICATION — PART I (LUC-141 1/13)

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135

GENERAL INFORMATION

Life Insurance for: First MI Last **Soc. Sec. No.**
☐ **Male** ☐ **Female**

Street/PO Box | City | State | Zip

Phone Number – Day Time | Phone Number – Evening | Email Address

Is this part of a Purchase Group? ☐ Yes ☐ No If Yes, Purchase Group number and/or name and relationship of group members:

Occupation	Annual Income	State of Birth

Height	Weight	Driver's License #	Date of Birth

Has the proposed insured used nicotine products of any kind in the past 12 months? ☐ Yes ☐ No

OWNER INFORMATION

1. Owner (if other than proposed insured)
Name | Soc. Sec./Tax ID: | Percent
Street/PO Box | City | State | Zip

2. Joint Owner (if other than proposed insured)
Name | Soc. Sec./Tax ID: | Percent
Street/PO Box | City | State | Zip

3. Joint Owner (if other than proposed insured)
Name | Soc. Sec./Tax ID: | Percent
Street/PO Box | City | State | Zip

For additional owners, please add the owner's name, address, social security or tax ID number and percentage owned in the Remarks section on page 2 of this application. All listed owners should sign the application in the authorization section at the bottom of page 3.

BENEFICIARY INFORMATION

(P-Primary, C-Contingent)

Name	Relationship	%	P	C
Any living children born of this marriage or legally adopted to share equally.				

PLAN

Plan Choice:

☐ Variable Life: Complete

☐ Other _____

Benefits/Riders:

☐ Other Benefits/Riders as available: _____

_____

OTHER COVERAGE/REPLACEMENT

	Yes	No
Does the proposed **insured** have any life insurance policies with this or any other company? (in force or applied for) If yes, provide <u>total</u> amount of life insurance coverage: $_____	☐	☐
Will any of these policies be terminated as result of this application? If yes, provide the total amount of coverage being terminated: $_____	☐	☐
Does **owner/applicant** have any other life insurance policies or annuity contracts with this or any other company? (in force or applied for)	☐	☐
To the best of the **owner/applicant's** knowledge, will the policy applied for replace any existing life insurance policy or annuity, or will any part of the premium to be paid by policy loan or cash value on insurance presently in force? (if yes, attach state replacement disclosure)	☐	☐
Will new policy have surrender charges?	☐	☐

Information for Owner/Applicant Policies

Company	Face Amount	Annual Premium	Policy Type	A - B = C		
				Cash Value (if replacing)	**Surrender Charge** (if replacing)	**If 1035 Exchange, Estimated Amount**

AGENT

	Yes	No
Does the **owner/applicant** have any existing life insurance policies or annuity contracts with this or any other company? (in force or applied for)	☐	☐
To the best of your knowledge, will this insurance replace or change any of the **owner/applicant's** existing life insurance or annuity contracts?	☐	☐

If replacing, how does this policy better serve the **owner/applicant's** needs?

PREMIUM PLAN

Premium Plan

Initial Premium: $_____ ☐ Non Sec. 1035 Exchange ☐ Sec. 1035 Exchange

From Policy Year	Through Policy Year	Non Sec. 1035 Premium Amount Per Year	Sec. 1035 Exchange Amount
1	1	$	$
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	

If any additional premium plan lines are needed, please use a separate page or put in the Remarks Section. Please do not remit any payment with application. Your agent will contact you to arrange payment when your application is approved. Life insurance coverage will begin on the Policy Date as shown on your policy.

REMARKS

Remarks:

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiner, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Company. This disclosure authorization will permit employees, agents or reinsurers of Symetra Life Insurance Company to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug use, alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Company obtain medical information only in connection with specific products or claims. Symetra Life Insurance Company will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this authorization or twenty-four (24) months after the date of signing this authorization. The individual signing this authorization has the right to revoke an authorization in writing, except to the extent that action has been taken in reliance on the authorization, or during a contestability period. A written statement revoking this authorization delivered to Symetra Life Insurance Company at their usual business addresses will revoke this authorization. Any copy of this authorization shall have the same authority as the original. I also understand that I have a right to receive a copy of this authorization upon request. I, the Owner, certify under the penalties of perjury that (1) the number shown in Applicant Info section is my correct taxpayer identification number, and (2) I am not subject to backup withholding.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I (we) agree that all statements and answers recorded on this application are true and complete to the best of my/our knowledge and shall form a part of any policy issued.

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud, excluding residents of Connecticut, Nebraska, and N. Carolina.

I UNDERSTAND THAT UNDER THE LIFE INSURANCE POLICY APPLIED FOR: (A) THE AMOUNT AND THE DURATION OF THE DEATH BENEFIT MAY VARY UNDER SPECIFIED CONDITIONS; (B) POLICY VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE INVESTMENT EXPERIENCE OF INVESTMENT OPTIONS ON A SEPARATE ACCOUNT; (C) THE AMOUNT PAYABLE AT THE FINAL POLICY DATE IS NOT GUARANTEED BUT IS DEPENDENT ON THE POLICY VALUE; AND, (D) THIS POLICY MEETS MY INVESTMENT OBJECTIVES AND ANTICIPATED FINANCIAL NEEDS.

I (We) hereby acknowledge receipt of the current Prospectus ☐

Signed this_____, at _____, State of _____
Date City State

_____ _____
Printed Name of Proposed Insured Print Name of Writing or Authorized Agent

_____ _____
Signature of Proposed Insured (Age 15 or older) Signature of Writing or Authorized Agent

_____ _____ _____
Signature of Applicant/Owner * if other than Proposed Insured Agent Phone Agent Email

_____ _____
Signature of Applicant/Joint Owner *if other than Proposed Insured Agent Stat Number

_____ _____
Signature Applicant/Joint Owner *if other then Proposed Insured Rep ID

[Branch Name _____ Branch #_____ 7-Digit Cost Center_____ Rep ID #_____]

* If applicant is corporation/partnership, a corporate officer/partner other than proposed insured must sign.

NOTICE OF INSURANCE INFORMATION PRACTICES

MIB, Inc. (Medical Information Bureau, MIB) – MIB, Inc. is a nonprofit corporation which operates an information exchange on behalf of its member life insurance companies. We are a member. The purpose of the MIB is to protect its member companies and their policyowners from those who would conceal significant facts relevant to their eligibility for insurance. The information we obtain from MIB may alert us to the possible need for further investigation. We rarely use it to make a final underwriting decision, but if we do, we will notify you in writing. As a member company, we will ask the MIB if it has a record about you. If you previously applied to a member company, MIB may have information about you in its file. We will treat information about you as confidential. Symetra Life or their reinsurers may, however, make a brief report to the MIB. This report is transmitted in a coded form, in order to maintain confidentiality, and only authorized underwriting and claims personnel have access to the code. If you later apply to another MIB member company for life or health insurance, or you submit a claim to a member company, MIB, upon request, will supply the member company with the information it may have about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Information for consumers about MIB may be obtained on its website at www.mib.com. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB may also be contacted at 1-866-692-6901 (TTY 1-866-346-3642).

Investigative Consumer Report – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, nicotine use, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this in the Remarks section on the reverse side of this application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You or your authorized representative, are entitled to a copy of this Notice.

Disclosure to Others – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to the Medical Information Bureau.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. We will give medical record information, however, only to a licensed physician of your choice or yourself. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Individual New Business Department of Symetra Life, P.O. Box 84068, Seattle, WA 98124-9918. Your comments will be carefully considered and corrections made where justified.

SYMETRA FINANCIAL

LO-1147 1/13
APPLICATION FOR REINSTATEMENT & EVIDENCE OF INSURABILITY

Symetra Life Insurance Company
Mailing Address:
[PO Box 7902, London, KY 40742-9899]

Street Address:
[777 108th Avenue NE, Suite 1200]
[Bellevue, WA 98004-5135]

☐ Symetra Life Insurance Company
☐ Symetra National Life Insurance Company

Policy Number _____ Primary Insured _____ Other Insured Rider _____
(Print Name) (Print Name)

Owner if other than Insured _____ Policy Owner Phone Number _____

Policy Owner Mailing Address _____
City State Zip

	Primary Insured	Other Insured Rider
Current Height		
Current Weight		
What is your current occupation?		
How long employed there?		

I (We) hereby apply for reinstatement of the policy and represent the following answers to be true and complete to the best of my (our) knowledge and belief. Reinstatement shall not take effect until this application is approved by us during the lifetime of any insured covered under the policy. I (We) understand this application shall become part of the policy and I (we) may request a copy of this application should I (we) so desire. I (We) acknowledge the representations made herein shall become incontestable as defined in the Incontestability provision contained in the policy. I (We) have also read the Notice of Insurance Information Practices.

		Primary Insured		Other Insured Rider	
		Yes	No	Yes	No
1.	During the past two (2) years has any insured previously covered under this policy:				
a.	Had an injury, medical disorder, disease, or physical impairment?	1a. ☐	☐	☐	☐
b.	Consulted or received any medical treatment or advice from a physician or any other licensed practitioner, or been under observation, care, or treatment in any hospital or any other treatment facility?	1b. ☐	☐	☐	☐
c.	Been declined, postponed, or limited for any insurance?	1c. ☐	☐	☐	☐
d.	Used any drug or narcotic except as prescribed by a licensed physician?	1d. ☐	☐	☐	☐
e.	Had any driver's license revoked or suspended, or been convicted of driving while impaired or a felony crime?	1e. ☐	☐	☐	☐
f.	Taken or been advised to take any prescribed medication, or treatment, or undergone any diagnostic tests (excluding Human Immunodeficiency Virus [HIV] tests)?	1f. ☐	☐	☐	☐
2.	To the best of your knowledge and belief, is anyone previously covered under this policy currently disabled or been disabled within the past two (2) years?	2. ☐	☐	☐	☐

		Primary Insured	Other Insured Rider
3.	What tobacco products or nicotine aids has any insured previously covered under this policy used in the previous 24 months? Check what type of product.	3.	
		☐ Cigarettes	☐ Cigarettes
		☐ Cigars	☐ Cigars
		☐ Pipe	☐ Pipe
		☐ Smokeless/Chew	☐ Smokeless/Chew
		☐ Gum	☐ Gum
		☐ Patch	☐ Patch
		☐ None	☐ None
		☐ Other (Please Name)	☐ Other (Please Name)
		_____	_____
	When was tobacco/nicotine last used?	_____	_____

If the answer to question 1 or 2 is "YES" – Please provide details below.

Name of Insured	Nature of Illness or Injury	Date	Duration of Illness	Treatment	Full Name & Address of Physician, Practitioner, Hospital or Treatment Facility

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize any physician, medical practitioner, hospital, medical clinic, other provider of health care, any insurance company, any consumer reporting agency or employer, or the MIB, Inc. to disclose to Symetra or Symetra National or their authorized medical, underwriting and claims representatives all information and records relating to diagnosis, treatment, medical history, physical and mental condition and evaluation, including information about drugs, alcoholism, or mental illness, or any other medical, financial or personal information relating to me or my dependent children. The Company will use this authorization to determine eligibility for insurance and/or benefits. This authorization is valid for 24 months from this date. A photocopy is as valid as the original. I understand I have a right to receive a copy of this authorization if I desire.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

FRAUD WARNING

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE BLOCK

There is no coverage in force until reinstatement is approved by Symetra and all required premiums are paid.

Signed this,_____ at_____ State of _____
Day Month Year

_____
Signature of Applicant/Owner If other than Proposed Insured

_____
Signature of Primary Insured (Age 15 or Older, 16 in CA)

_____
Signature of Other Insured Rider (Age 15 or Older, 16 in CA)

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Disclosure to Others – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to the Medical Information Bureau.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. We will give medical record information, however, only to a licensed physician of your choice or yourself. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Individual New Business Department of Symetra, PO Box 84068, Seattle, WA 98124-9918. Your comments will be carefully considered and corrections made where justified.

Symetra Life Insurance Company
[777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135]
Send to: **[Attn: Financial Inst. Team** Fax: 1-888-274-0802]
[PO Box 84068 | Seattle, WA 98124-9718]

LIFE INSURANCE APPLICATION
FOR SINGLE PREMIUM LIFE INSURANCE — PART I LUC-168 1/13

PERSONAL HISTORY

Proposed Insured Name First Middle Last	☐ Male ☐ Female	Soc. Sec. or Tax I.D. #
Address Street/PO Box	City	State Zip
Daytime Phone	Evening Phone	

	Yes	No
1. Within the past 12 months, has Proposed Insured:		
A. been admitted to a hospital or been advised by a medical professional to be admitted for other than joint replacement or simple appendectomy?	☐	☐
B. been unable to work or perform their regular activities without assistance such as bathing, getting dressed, or cooking meals for more than 7 consecutive days due to illness or injury?	☐	☐
C. lost 10 pounds or more other than due to diet or exercise program?	☐	☐
D. been advised by a medical professional to have diagnostic testing or medical treatment that has not been completed?	☐	☐
2. Within the past 5 years, has the Proposed Insured had a violation of reckless driving, driving under the influence of alcohol or drugs, or had their license suspended or revoked?	☐	☐
3. Within the past 5 years, has the Proposed Insured tested positive for or been treated for the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS) caused by HIV infection or other sickness or condition derived from such infection?	☐	☐

4. Within the past 5 years, has the Proposed Insured received medical advice, treatment or been hospitalized for:

	Yes	No		Yes	No
Heart disease or disorder	☐	☐	Bipolar disorder or suicide attempt	☐	☐
Cancer (not basal cell) Lymphoma or Leukemia	☐	☐	Kidney or Liver disease or disorder	☐	☐
Stroke or Transient Ischemic Attack (TIA)	☐	☐	Pancreas disease or disorder	☐	☐
Carotid Artery or Peripheral Vascular Disease	☐	☐	Alcohol or Drug use	☐	☐
Cognitive Impairment, Dementia or Alzheimer's	☐	☐	ALS or Lou Gehrig's disease	☐	☐
COPD, Emphysema or Chronic Bronchitis	☐	☐	Diabetes treated with insulin	☐	☐

If client answers "yes" to one (1) of questions 1-4, they are *not eligible* for this life insurance product.

5. Within the past 10 years, has the Proposed Insured received medical advice, treatment or been hospitalized for:

	Yes	No		Yes	No
Anemia or other blood disorder	☐	☐	Diabetes treated with diet or oral medication	☐	☐
Crohn's disease or Ulcerative Colitis	☐	☐	Loss of consciousness or fainting	☐	☐
Central Nervous System disease or disorder	☐	☐	Respiratory disease or disorder (not Asthma)	☐	☐
Depression or Anxiety disorder	☐	☐	Tumor or mass (non-cancerous)	☐	☐

	Yes	No
6. Within the past 5 years, has the Proposed Insured been declined or turned down for life insurance? For any "yes" answer above, please provide physicians' names, address, dates and treatment in the remarks section below	☐	☐
7. Within the past 24 months, has the Proposed Insured used any form of tobacco or nicotine based products?	☐	☐

REMARKS

Please explain any "yes" answer to questions 1-6, including physicians' names, addresses, dates and treatments. Attach an additional sheet if needed.

PROPOSED INSURED INFORMATION

Occupation	Annual Income	State or Foreign Country of Birth

Height	Weight	Driver's License #	Date of Birth

Insurance Needed For: ☐ Estate Planning ☐ Other: _____

If Policyowner is other than the Proposed Insured, provide their **name** and **Social Security** or **Tax I.D. Number:** _____

BENEFICIARY INFORMATION

	Name (first, middle initial, last)	Date of Birth/Trust	SSN or TIN	Relationship to Proposed Insured	%
☐ **P**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					

P – Primary **C – Contingent**

Please add information about additional beneficiaries in the Remarks section. The percentage for each product and each type of beneficiary must total 100%. Do not indicate multiple beneficiaries as a group – e.g., "All Children of Proposed Insured/Annuitant."

COVERAGES

Premium $_____ **Amount of Life Insurance Coverage** $_____ **Net Credited Interest Rate** _____%

[Return of Premium ☐ Yes ☐ No]

APPLICANT REPLACEMENT

8. Does the Proposed Insured have other existing life insurance policies or annuity contracts inforce or applied for with this or any other company?	Yes ☐	No ☐

Company	MO/YR Issued	Face Amount	Policy Type	Annual Premium

9. To the best of the Applicant's knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (if yes, attach state replacement disclosure)	Yes ☐	No ☐

10. If the policy being replaced has cash value or surrender charges, please provide this information in the remarks section, on the first page of this application.

INSURANCE PRODUCER REPLACEMENT

	Yes	No
11. Does the Applicant have existing life insurance or annuity contracts with this or any other company?	☐	☐
12. To the best of your knowledge, will this insurance replace or change any existing life insurance or annuity?	☐	☐

13. If replacing, how does this policy better serve the Applicant's needs?

ADDITIONAL INFORMATION

For any "Yes" answers to questions 14 – 16, please provide details in the Remarks section.	Yes	No
14. Does the applicant/owner or proposed insured intend to assign or sell, or have they been involved in any discussion about the possible sale or assignment of, the life insurance policy for which the application is being made?	☐	☐
15. Has the applicant/owner or proposed insured ever sold a policy to a life settlement, viatical or other secondary market provider, or are they in process of selling a policy?	☐	☐
16. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity?	☐	☐

PAYMENT & TEMPORARY INSURANCE

Premium Payment:

☐ Check ☐ Wire Transfer Funds to Symetra Life Payment with Application $_____

Who is providing the premium for this policy? _____

If your face amount is $1,000,000 or less and you answered "no" to questions 1-4, you will be covered under the Temporary Life Insurance Agreement if a check is collected for the payment or if you authorize payment by wire (Maximum coverage is $250,000).

REMARKS

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiner, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Company. This disclosure Authorization will permit employees, agents or reinsurers of Symetra Life Insurance Company to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug or alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Company obtains medical information only in connection with specific products or claims. Symetra Life Insurance Company will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This Authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this Authorization or twenty-four (24) months after the date of signing this Authorization. The individual signing this Authorization has the right to revoke Authorization in writing, except to the extent that action has been taken in reliance on the Authorization, or during a contestability period. A written statement revoking this Authorization delivered to Symetra Life Insurance Company at its usual business address will revoke this Authorization. Any copy of this Authorization shall have the same authority as the original. I also understand that I or my representative have a right to receive a copy of this Authorization upon request.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I, the Owner, certify under the penalties of perjury that (1) the number shown in Personal History section is my correct taxpayer identification number, and (2) I am not subject to backup withholding.

I (we) agree that all statements and answers recorded on this application are true and complete to the best of my/our knowledge and belief, and shall form a part of any policy issued. I have also read the Temporary Life Insurance Agreement. (Max. Coverage is $250,000.)

For Residents of Other States not listed below: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

I acknowledge this insurance policy was not a prerequisite to receiving credit, property or services from any bank and that the amount of insurance I am applying for may not meet my complete financial needs. I have received information both orally and in writing stating that this insurance product is not a deposit or other obligation of, or guaranteed by, any bank or an affiliate of a bank and that the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of a bank.

Signed this _____, at _____, State of _____
Date City State

_____ _____
Printed Name of Proposed Insured Printed Name of Writing or Authorized Insurance Producer

_____ _____
Signature of Proposed Insured (Age 15 or older) Signature of Writing or Authorized Insurance Producer

_____ _____ _____
Signature of Applicant/Owner* if other than Proposed Insured Insurance Producer Phone Insurance Producer Stat Number

_____
Insurance Producer Email

Branch Name _____ Branch # _____ Rep ID # _____

*If Applicant is corporation/partnership, a corporate officer/partner other than Proposed Insured must sign.

NOTICE OF INSURANCE INFORMATION PRACTICES

MIB, Inc. (Medical Information Bureau, MIB) – Information regarding your insurability will be treated as confidential. Symetra Life or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Information for consumers about MIB may be obtained on its website at www.mib.com. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB may also be contacted at 1-866-692-6901 (TTY 1-866-346-3642). Symetra Life or its reinsurers may also release information in its file to others insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Investigative Consumer Report – As a part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application about your employment, residence, finances, smoking habits, marital status, occupation, hazardous avocations and general health. This report may also include information concerning your general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation, including drug and alcohol use, motor vehicle driving record and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors and business associates. If a report is required, you may request to be personally interviewed. If you wish to be personally interviewed, request this in the remarks section on the reverse side of this application and we will notify the consumer reporting agency.

The information contained in the report may be retained by the consumer reporting agency and later disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. We hold investigative consumer reports in strict confidence, and we use them only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of this report from the consumer reporting agency. Such a report rarely has an adverse effect on an individual's eligibility for insurance. If it should, however, we will notify you in writing, and identify the reporting agency. You, or your authorized representative, are entitled to a copy of this Notice.

Disclosure to Others – Personal information we obtain about you during the underwriting process is confidential, and we will not disclose it to other persons or organizations without your written authorization, except to the extent necessary for the conduct of our business. Examples of situations where we may share information about you follow:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company will have access to our application file. We give the consumer reporting agency enough identity information about you so that it may initiate a consumer report investigation.
2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to MIB.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Individual New Business Department of Symetra Life, PO Box 84068, Seattle, Washington 98124-9918. Your comments will be carefully considered and corrections made where justified.

TEMPORARY LIFE INSURANCE AGREEMENT

AMOUNT OF COVERAGE: If the Temporary Life Insurance questions (questions 1-4 in Personal History Section) have been answered "no" and if money has been accepted as advance payment for life insurance and the proposed insured dies while this temporary insurance is in effect, we will pay the beneficiary an amount equal to the lesser of:

(a) the amount of all death benefits applied for with this application, including any accidental death benefits, if applicable; or
(b) a maximum amount under all Temporary Life Insurance Agreements with Symetra of $250,000.

COVERAGE BEGINS: Life insurance under this Agreement will begin on the date of this application, if the Temporary Life Insurance questions have been completed and answered "no" and money equal to the first full premium has been accepted as advance payment for life insurance.

COVERAGE ENDS: Life insurance under this Agreement will terminate on the earliest of:

(a) 90 days from the date of this Agreement; or
(b) the date that insurance takes effect under the policy applied for; or
(c) the date a policy, other than as applied for, is offered to the Applicant; or
(d) the date the Company mails notice of termination of coverage and a return of the payment to the Applicant.

LIMITATIONS:

(a) This Agreement does not provide benefits for disability.
(b) Fraud or material misrepresentation in the application or in the answers to the questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of the payment made.
(c) If the Proposed Insured is less than 15 years old or more than 85 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
(d) If the Proposed Insured commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made. (For citizens of Missouri, suicide is no defense unless we can show that the insured intended suicide when the application was completed.)
(e) If the payment is not honored by the bank, there is no coverage under this Agreement.
(f) No one is authorized to waive or modify the terms of this Agreement.

Symetra Life Insurance Company
[777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135]
Send to: **[Service Center:** Fax: 1-888-274-0802]
[PO Box 84068 | Seattle, WA 98124-9718]

LIFE INSURANCE APPLICATION — PART I LUC-170 1/13

PROPOSED INSURED INFORMATION

Life Insurance for First MI Last ☐ Male ☐ Female				Soc. Sec./Tax I.D.
Street/PO Box		City	State	Zip
Phone Number		Best Time to call	Best Day to call	
Occupation	Employer	Annual Income	State of Birth	
Height	Weight	Driver's License #	Date of Birth	
Owner if other than Proposed Insured		Soc. Sec./Tax I.D.	Relationship	
Owner Address Street/PO Box		City	State	Zip
Insurance Needed For ☐ Debt/Family/Business Protection ☐ Income Replacement ☐ Retirement/Estate Planning ☐ Other _____				

COVERAGES

Amount of Coverage $	**Quoted Premium $**	**Net Credited Interest Rate (SPL Only)** **%**
[Plan Choice	**[Riders**	
]		]

RATE CLASS

Rate class applied for (Check one only)

	Juvenile	Standard (Nicotine)	Non-Nicotine (Standard)	Standard Plus (Nicotine)	Preferred (Non-Nicotine)	Preferred Plus (Non-Nicotine)	Preferred Best (Non-Nicotine)
Term Plan	N/A						
Term Plan with ROP	N/A					N/A	N/A
UL							
VUL	N/A						
	Juvenile	**Traditional (Nicotine)**	**Traditional (Non-Nicotine)**	**Preferred (Nicotine)**	**Preferred (Non-Nicotine)**	**Preferred Plus (Non-Nicotine)**	**Preferred Best (Non-Nicotine)**
SPL	N/A					N/A	N/A

BENEFICIARY INFORMATION

The percentage for each product and each type of beneficiary must total 100%. Do not indicate multiple beneficiaries as a group – e.g., "All Children of Proposed Insured." If more space is needed, please add additional beneficiaries in the Remarks section.

P = Primary C = Contingent	Name (first, middle initial, last) or Organization Name and Address	Date of Birth/Trust	SSN, TIN or 501(c) Tax ID Number	Relationship to Proposed Insured	%
☐ **P**					
☐ **P**					
☐ **P** ☐ **C**					
☐ **P** ☐ **C**					

[Charitable Giving Rider]

TEMPORARY INSURANCE

Temporary Life Insurance Agreement (TIA) questions: For any "Yes" answers to questions 1 – 2 please provide details in the Remarks section, including doctor names, addresses, dates and treatments.	**Yes**	**No**
1. Within the past 90 days, has the Proposed Insured been admitted to, or been advised to be admitted to, a hospital?	☐	☐
2. In the past two years has the Proposed Insured been treated for: heart disease, stroke, tumor, mass, cancer, alcohol, drugs, or Acquired Immunodeficiency Syndrome (AIDS)/Aids Related Complex (ARC) by a medical professional?	☐	☐

If you are under age 81 and your face amount is $1,000,000 or less and you answered NO to the TIA questions above, you will be covered under the TIA if a check is collected for the initial payment or you sign up for initial payment by EFT or wire transfer (maximum coverage is $250,000) . NOTE TO AGENT/INSURANCE PRODUCER: For any Yes answers to questions 1 - 2 or if the face amount is greater than $1,000,000, do not collect premium. No TIA coverage will be in effect.

APPLICANT REPLACEMENT

				Yes	**No**
1. Do you have any other existing insurance policies or annuity contracts in force or applied for with this or any other company?				☐	☐
Company	MO/YR Issued	Face Amount	Policy Type	Annual Premium	
2. To the best of the Applicant's knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (If yes, attach state replacement disclosure.)				**Yes** ☐	**No** ☐
3. Existing Policy Cash Value $ _____	Amount of Surrender Charge $ _____				
4. Will new policy have surrender charges?				☐	☐

INSURANCE PRODUCER REPLACEMENT

	Yes	No
1. Does the Applicant have any existing life insurance policies or annuity contracts with this or any other company?	☐	☐
2. To the best of your knowledge, will this insurance replace or change any existing life insurance or annuity?	☐	☐

3. If replacing, how does this policy better serve the Applicant's needs?

ADDITIONAL INFORMATION

Additional Information: For any "Yes" answers to questions 1 – 3, please provide details in the Remarks section.

	Yes	No
1. Does the applicant/owner or proposed insured intend to assign or sell, or have they been involved in any discussion about the possible sale or assignment of, the life insurance policy for which the application is being made?	☐	☐
2. Has the applicant/owner or proposed insured ever sold a policy to a life settlement, viatical or other secondary market provider, or are they in process of selling a policy?	☐	☐
3. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity?	☐	☐

PAYMENT INFORMATION

Payment Method:

☐ Automatic EFT* ☐ Check ☐ Wire transfer to Symetra (SPL Only)

Payment With Application: $_____

Who is providing the premium for this policy?_____

Payment Frequency:

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly EFT* ☐ Single Payment

For all payments (initial and future) to be taken by EFT, please complete the following:

Name On Account _____ ☐ Checking ☐ Savings Bank Name _____

Routing # _____ Account # _____ Draft date (not the 29th, 30th, 31st) _____

*Marking this box authorizes us to automatically deduct from your checking or savings account by electronic funds transfer (EFT).

REMARKS

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I hereby authorize and request any medical care provider, pharmacy, pharmacy benefits manager, individual employer, insurance company, reinsuring company, medical examiners, government unit, consumer reporting agency, or other person or organization, and MIB, Inc., to disclose any and all medical information, non-medical information, employment information, and insurance information they hold concerning me, to the employees, agents, or attorneys of Symetra Life Insurance Company. This disclosure Authorization will permit employees, agents or reinsurers of Symetra Life Insurance Company to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug or alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of HIV (AIDS virus) and/or other sexually-transmitted diseases. Symetra Life Insurance Company obtains medical information only in connection with specific products or claims. Symetra Life Insurance Company will not use or share personally identifiable medical information for any purpose other than the underwriting or administration of your policy, claim or account. I understand that the information obtained pursuant to this Authorization will be used for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, with respect to my application for insurance, or claim under a policy of insurance. This Authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this Authorization or twenty-four (24) months after the date of signing this Authorization. The individual signing this Authorization has the right to revoke Authorization in writing, except to the extent that action has been taken in reliance on the Authorization, or during a contestability period. A written statement revoking this Authorization delivered to Symetra Life Insurance Company at its usual business address will revoke this Authorization. Any copy of this Authorization shall have the same authority as the original. I also understand that I or my representative have a right to receive a copy of this Authorization upon request.

I authorize Symetra Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I, the Owner, certify under the penalties of perjury that (1) the number shown in Proposed Insured Information section is my correct taxpayer identification number, and (2) I am not subject to backup withholding.

I (we) agree that all statements and answers recorded on this application are true and complete to the best of my/our knowledge and belief, and shall form a part of any policy issued. I have also read the Temporary Life Insurance Agreement. (Maximum Coverage is $250,000.)

Fraud Warnings

Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Oregon Residents: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a materially false or deceptive statement may be guilty of insurance fraud.

I acknowledge this insurance policy was not a prerequisite to receiving credit, property or services from any bank and that the amount of insurance I am applying for may not meet my complete financial needs. I have received information both orally and in writing stating that this insurance product is not a deposit or other obligation of, or guaranteed by, any bank or an affiliate of a bank and that the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of a bank.

Signed this _____, at _____, State of _____
Date City State

_____ _____
Printed Name of Proposed Insured Print Name of Writing or Authorized Insurance Producer

_____ _____
Signature of Proposed Insured (Age 15 or older) Signature of Writing or Authorized Insurance Producer

_____ _____ _____
Signature of Applicant/Owner* if other than Proposed Insured Insurance Producer Phone Insurance Producer Stat Number

_____
Insurance Producer Email

Branch Name _____ Branch # _____ Cost Center #_____Rep ID # _____

* If Applicant is corporation/partnership, a corporate officer/partner other than Proposed Insured must sign.

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2. We may release information to another life insurance company to whom you have applied for life or health insurance, or to whom you have submitted a claim for benefits, if you have authorized that company to obtain such information, and it submits your authorization to us with its request for information.
3. As stated earlier, we may report information to MIB.
4. We may release information to persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to our affiliates who may wish to market products or services.
5. We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

Access and Correction – In general, you have a right to learn the nature and substance of any personal information about you in our file, upon your written request. Whenever we make an adverse underwriting decision, we will notify you of the reasons for the decision and the source of the information on which we based our decision. Please refer to the section on MIB, Inc., for that organization's disclosure procedure. There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request. If you feel that any information we have is inaccurate or incomplete, please write to the Life New Business Department of Symetra Life, PO Box 84068, Seattle, Washington 98124-9918. Your comments will be carefully considered and corrections made where justified.

TEMPORARY LIFE INSURANCE AGREEMENT

AMOUNT OF COVERAGE: If the Temporary Life Insurance questions have been answered "no" and if money has been accepted as advance payment for life insurance and the Proposed Insured dies while this temporary insurance is in effect, we will pay the beneficiary an amount equal to the lesser of:

(a) the amount of all death benefits applied for with this application, including any accidental death benefits, if applicable; or
(b) a maximum amount under all Temporary Life Insurance Agreements with Symetra Life of $250,000.

COVERAGE BEGINS: Life insurance under this Agreement will begin on the date of this application, if the Temporary Life Insurance questions have been completed and answered "no" and money equal to the first full premium has been accepted as advance payment for life insurance.

COVERAGE ENDS: Life insurance under this Agreement will terminate on the earliest of:

(a) 90 days from the date of this Agreement; or
(b) the date that insurance takes effect under the policy applied for; or
(c) the date a policy, other than as applied for, is offered to the Applicant; or
(d) the date the Company mails notice of termination of coverage and a return of the payment to the Applicant.

LIMITATIONS:

(a) This Agreement does not provide benefits for disability.
(b) Fraud or material misrepresentation in the application or in the answers to the questions of this Agreement invalidate this Agreement and the Company's only liability is for refund of the payment made.
(c) If the Proposed Insured is less than 15 days old or more than 80 years old, the Company's liability under this Agreement is limited to a refund of the payment made.
(d) If the Proposed Insured commits suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
(e) If the check or draft submitted as payment is not honored by the bank, there is no coverage under this Agreement.
(f) No one is authorized to waive or modify the terms of this Agreement.

SERFF Tracking #:	*SYMT-128597574*	***State Tracking #:***	***Company Tracking #:*** *LUC-18 1/13*

State:	*Arkansas*	***Filing Company:***	*Symetra Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*MIB Application Revision*		
Project Name/Number:	*MIB Application Revision/LUC-18 1-13 et al*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Certification.pdf AR-Certificate of Readability.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application		
Comments:	The applications are the forms being filed and are attached to the Form Schedule.		

State of Arkansas

CERTIFICATION

LUC-18 1/13
LUC-128 1/13
LUC-141 1/13
LUC-168 1/13
LUC-170 1/13
LO-1147 1/13

I hereby certify that we are in compliance with 23-79-138; Bulletin 6-87; Bulletin 11-88; and Regulation 49.

Suzanne Webb Sainato, V.P.
Chief Compliance Officer
Symetra Life Insurance Company

CERTIFICATION OF READABILITY

To the best of my knowledge, these forms meet all applicable statutes and regulations for readability standards. The Flesch scores are:

LUC-18 1/13 – 50.9
LUC-128 1/13 – 50.2
LUC-168 1/13 – 50.1
LUC-170 1/13 – 52.1
LO-1147 1/13 – 50.2

Suzanne Webb Sainato, V.P.
Chief Compliance Officer
Symetra Life Insurance Company